Millennium Wellness Group
111 N. Wabash, suite 600
Chicago, IL 60602
p. (312)332-0844

PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and have been provided with the opportunity to review it.

Name _____ DOB_____ Signature _____ Date _____

CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____ by Dr. Jennifer Beverlin and/or Dr. Tanya Freseth, D.C., and/or other licensed doctors of chiropractic who may be employed or engaged in practice in Millennium Wellness Group.

I have had an opportunity to discuss with Dr. Beverlin and/or Dr. Freseth, D.C., or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic or medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment that no guarantee as to results has been made to nor relied upon by me and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts then known is in my best interests.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of possible complications which have been alleged. These include, but are not limited to: fractures, disc injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to one above consent. I have also had an opportunity to ask questions about its contents and by signing below, acknowledge my understanding of its contents.

Date: _____

_____
Patient Name

Doctor's Notes:

_____
Patient Signature

_____
Relationship or Authority
(if not signed by patient)

Patient counseled by use of the following:

_____ Discussion

_____
Signature of Doctor or Other

_____ Other (please specify)